HOSPITAL ACCREDITATION AND COMPLIANCE WITH MEDICARE'S CONDITIONS OF PARTICIPATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JUNE 21, 1990

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HOSPITAL ACCREDITATION AND COMPLIANCE WITH MEDICARE'S CONDITIONS OF PARTICIPATION

THURSDAY, JUNE 21, 1990

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 12:30 p.m., in room 1310A, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
FRIDAY, JUNE 8, 1990

PRESS RELEASE #33
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON HOSPITAL ACCREDITATION AND COMPLIANCE WITH MEDICARE'S CONDITIONS OF PARTICIPATION

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on hospital accreditation and compliance with Medicare's conditions of participation. The hearing will be held on Thursday, June 21, 1990, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

To be approved for participation in the Medicare program, a hospital must be in compliance with health, safety, and organizational standards, referred to as the Medicare conditions of participation. There are 19 conditions of participation relating to areas such as quality assurance, nursing services, infection control, and State and local law.

The Health Care Financing Administration (HCFA) is required to accept accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) as proof that a hospital is meeting the Medicare conditions of participation. Such hospitals are considered to have "deemed status" with regard to the conditions of participation.

HCFA is also required to conduct surveys of JCAHO-accredited hospitals to validate the JCAHO accreditation process. HCFA conducts these surveys on a selective sample basis, or in response to complaints. These surveys are conducted by State licensure and survey agencies working under contract with HCFA.

JCAHO surveys each hospital at least once every three years. If a hospital does not choose to be accredited by JCAHO, it is termed a nonaccredited hospital and is surveyed once a year by the State agency.

At the request of Chairman Stark, the General Accounting Office has been studying the accreditation process and HCFA's ability to assure that accredition provides sufficient protections for Medicare's beneficiaries.

The GAO study will focus on three specific issues: (a) whether HCFA is performing sufficient validation surveys to assess the effectiveness of JCAHO accreditation surveys; (b) whether HCFA surveys routinely identify findings which are at variance with JCAHO findings; and (c) whether the validation surveys are effective in determining whether problems identified by JCAHO are corrected.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, July 13, 1990, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

* * * CHANGE OF TIME AND LOCATION * * *

FOR IMMEDIATE RELEASE
TUESDAY, JUNE 19, 1990

PRESS RELEASE #33-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A NEW LOCATION FOR THE HEARING ON
HOSPITAL ACCREDITATION AND COMPLIANCE WITH
MEDICARE'S HOSPITAL CONDITIONS OF PARTICIPATION

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced that the Subcommittee's hearing on hospital accreditation and compliance with Medicare's conditions of participation, originally scheduled for 10:00 a.m., Thursday, June 21, 1990, in the main Committee hearing room, 1100 Longworth House Office Building, has been rescheduled for 11:00 a.m., in room 1310-A Longworth House Office Building.

All other details for the hearing remain the same. (See press release #33, dated June 8, 1990.)

* * * * *

Chairman STARK. We have just concluded a briefing on the specific problems at specific hospitals; however, the members have had to take care of some other business, and will be returning shortly. We would like to review publicly now the facts about a number of hospitals that do not review surgical cases.

These hospitals may not have a way to protect beneficiaries against unnecessary surgery. Hospitals which do not have protective control systems have been identified for us.

They may not check the adequacy of sterilization procedures. Certain hospitals do not conduct blood usage reviews, which are designed to protect patients against receiving tainted blood.

It goes without saying that the public has a real fear of not only AIDS, but hepatitis, and other viruses that could be spread through the blood. We found hospitals which cannot document that they are not dumping poor patients. Indeed, it seems to me, it is the hospital's responsibility to be able to document that.

Nor can they assure us their patients are not held in an emergency room too long prior to receiving necessary treatment.

The biggest problem—one verified by the GAO—is this: there is a long period of time between identification of a problem by the joint commission, and the followup. In our own case, there is a long period of time before the Federal Government does much.

Unfortunately, there is no clear indication of what we should do. We can make information public, but we really do not have a policy or rule about when to tell Medicare beneficiaries that they are at risk.

So I look forward to hearing these discussions. I think the committee would join me if they were here in agreeing that we need to design a better way. This is not, as we started out saying this morning, a session designed to find fault.

Fault is not a good, useful concept. It doesn't help us. The fact is that we need to improve the way we review hospitals for quality. We need to have some clear-cut ways to disseminate this information to the public who probably can't understand the various review systems that are in effect now.

You have to be able to say to me or your relatives: This is a risky hospital, if it is the only one in town, maybe it is better than nothing; or you have to say you shouldn't go there at all; the chance is you will come out sicker than when you went in.

Somehow or other, we ought to be able to know that and communicate that to our beneficiaries.

[The statement of Mr. Stark follows:]

OPENING STATEMENT OF HON. PETE STARK

Today, the Subcommittee will investigate issues related to hospital accreditation and compliance with Medicare's conditions of participation.

The focus of our hearing today will be a report from the General Accounting Office assessing the effectiveness of the Health Care Financing Administration's process to validate the results of accreditation decisions of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Validating the JCAHO process is critical, given that HCFA, through a process termed "deemed status," relies on JCAHO to assure that most hospitals are providing quality health services to Medicare beneficiaries. If a hospital is accredited by JCAHO, it is deemed to meet the Medicare conditions of participation.

The results of the GAO report are unsettling, to say the least.

The major conclusion of GAO's report is that given the total difference in the criteria against which HCFA surveys and those against which JCAHO surveys, we can't really tell anything about whether hospitals are meeting the Medicare conditions of participation.

Moreover, given that HCFA has never made a comprehensive comparison of the two sets of criteria, we don't really know very much at all about the performance of hospitals reviewed by JCAHO.

It is one thing to turn over to a private body what is essentially a public function—assuring that hospitals are providing quality standards or oversight by the government whatsoever.

GAO has also reviewed how well JCAHO does in forcing corrections at problem hospitals. As they will report, the delays in forcing hospitals to come into compliance, and the lack of followup by JCAHO on problem hospitals raises the possibility that the whole accreditation process is futile.

We have just completed a briefing on specific problems at specific hospitals. The results raise a number of concerns about the quality of hospital services.

We need to design a better way.

Should deemed status be limited or eliminated?

Are hospitals really entitled to confidentiality when they fail to pass muster?

Should JCAHO and HCFA standards be the same?

I look forward to discussing these and other important questions with our witnesses.

Chairman STARK. The first witness is David Baine, Director of Federal Health Care Delivery Issues for the Human Resources Division of GAO; James Carlan, Assistant Director of Quality Health Care Issues, Michelle Roman and Mary Ann Curran, Senior Evaluators.

Would you like to proceed?

STATEMENT OF DAVID P. BAINE, DIRECTOR, FEDERAL HEALTH CARE DELIVERY ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY JAMES CARLAN, ASSISTANT DIRECTOR, QUALITY HEALTH CARE ISSUES; MICHELLE ROMAN, SENIOR EVALUATOR; AND MARY ANN CURRAN, SENIOR EVALUATOR

Mr. BAINE. Thank you, Mr. Chairman. I have a short set of remarks.

If I could ask permission, I would request our full statement be included in the record.

Chairman STARK. Without objection.

Democracy is wonderful.

Mr. BAINE. It certainly is.

Mr. Chairman, we appreciate the opportunity to present our views on the system being used to assure that hospitals are capable of providing quality health care to Medicare beneficiaries.

The Department of Health and Human Services Health Care Financing Administration relies on the Joint Commission on the Accreditation of Health Care Organizations to act on its behalf to assure that problems in most hospitals serving Medicare patients are identified and resolved.

HCFA contracts with State agencies to conduct surveys of those hospitals that choose not to be accredited by the commission to assure that they are in compliance with Medicare requirements. HCFA also contracts with State agencies to conduct a small number of surveys in hospitals accredited by the joint commission. HCFA uses these surveys to help it assess the validity of the joint

commission survey process and to assure that Medicare conditions of participation are being met.

As we reported to you last week, HCFA's reviews of the accreditation process have not provided the necessary assurance hospitals are complying with these conditions of participation.

Until 2 days ago, HCFA had relatively limited access to joint commission survey data. Thus the extent to which problems existed in hospitals and whether they were corrected were generally unknown to HCFA.

However, under the Public Law 101-239, which was passed in 1989, HCFA is now authorized to obtain any survey information it wants from the joint commission. If HCFA requests the right information from the commission and uses it properly, it should be able to identify any accredited hospital serving Medicare patients that has serious problems and be aware of the efforts made by the commission to assure corrective actions are being taken.

HCFA's access to joint commission data and the opportunities it presents for Federal intervention does, however, raise a significant issue. That issue is what should the relative roles of HCFA and the joint commission be in assuring that hospitals can provide quality care and how should those roles be played out?

As discussed in more detail in my prepared statement, we think two issues illustrate why the roles of HCFA and the joint commission need to be clarified.

First, HCFA has not clearly identified its Medicare conditions of participation in the joint commission standards. Nor has it developed a usable guideline to determine whether the findings in the commission survey reports relate to Medicare conditions of participation. As a result, it does not know whether the accredited hospitals are capable of providing high quality care.

Second—and you alluded to this in your opening statement, Mr. Chairman—the joint commission's process for following up on corrective actions taken by hospitals in which problems have been identified takes much longer than HCFA believes is appropriate.

As a result——

Chairman STARK. You don't mean that they are doing it as fast as they can? This is not a criticism of the joint commission? The way the system works, you are suggesting, is not fast enough?

Mr. BAINE. What I am suggesting, Mr. Chairman, is that the system takes longer than HCFA would like it to. I think if you discuss the process with Dr. O'Leary, he, too, would agree the joint commission can collapse its process to identify hospitals with problems more efficiently.

Chairman STARK. Compress?

Mr. BAINE. Pardon me, sir?

Chairman STARK. Compress, not collapse.

Mr. BAINE. Compress. You are absolutely right.

Because of the long time it takes for followup action, HCFA does not know whether serious problems serving Medicare patients are being corrected promptly. Moreover, HCFA is not assured of its authority to direct the joint commission to alter its accreditation process to meet HCFA standards.

Based on the work we did for the report we issued to you last week, and some ongoing work we now have in process to answer

additional questions that you asked, we believe that HCFA should attempt to guide the joint commission's activities to assure hospitals meat Medicare requirements. Specifically, HCFA and the commission need to work together to assure that the commission standards relating to Medicare conditions of participation are identified and that the commission survey reports can be used to determine whether hospitals are out of compliance with those conditions of participation.

Further, HCFA and the joint commission should reach a mutually satisfactory solution to assure that hospitals promptly correct problems the commission identifies that relate to the conditions of participation and that HCFA is quickly informed of these actions.

If HCFA and the joint commission cannot agree on these issues, there are alternatives to HCFA's reliance on the present system of commission accreditation. Such options could include establishing an organization within HCFA to conduct all hospital surveys, contracting with State agencies to conduct all hospital surveys, or contracting with another private organization other than the commission to do this.

Each of these potential alternatives would be time consuming to establish, would probably be costly, and would likely require changes in the existing Medicare legislation.

Mr. Chairman, none of the above alternatives appears to us to be clearly superior to the current system if it were operating efficiently and well. Thus, we believe if HCFA finds it cannot make the system work effectively within its existing legislative authority, the Congress should consider providing HCFA the authority it needs to be sure the joint commission's accreditation process is effectively serving the Medicare population.

That concludes my summary. We will be more than happy to answer your questions.

[The prepared statement follows:]

Statement of David P. Baine, Director, Federal Health Care Delivery Issues, Human Resources Division, U.S. General Accounting Office

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to present our views on the system being used to assure that hospitals are capable of providing quality care to Medicare patients.

Since 1987, several large hospitals in major U.S. cities have been identified in the media as providing substandard care. Various articles have cited incidents involving questionable patient deaths, incorrect medications, infections due to poor quality care, and generally unsanitary conditions, together with graphic examples of the impact such care is having on patients. In essence, the effectiveness of the systems to assure that quality care is provided in our nation's hospitals is being questioned. We found that, in some cases, this challenge is justified.

The Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA) relies on the Joint Commission on Accreditation of Healthcare Organizations to act on its behalf to assure that problems in most hospitals serving Medicare patients are identified and resolved. The Joint Commission accredits over 5,000 of the approximately 6,700 hospitals participating in Medicare. HCFA contracts with state agencies to conduct surveys of those hospitals that choose not to be accredited by the Commission to assure that they are in compliance with Medicare requirements.

HCFA also contracts with state agencies to conduct a small number of surveys in hospitals accredited by the Joint Commission. HCFA uses these surveys to help it assess the validity of the Joint Commission survey process and to assure that Medicare conditions of participation are being met.[1] But, to date, HCFA's reviews of the Commission's accreditation process have not provided it the necessary assurance that hospitals serving Medicare patients are complying with its conditions of participation.

Until 2 days ago, HCFA had relatively limited access to Joint Commission survey data. Thus, the extent to which specific problems existed in hospitals, and whether they were corrected, were generally unknown to HCFA. However, under P.L. 101-239, HCFA is now authorized to obtain any survey data it wants from the Joint Commission. If HCFA requests the right information from the Commission and uses it properly, HCFA should be able to identify any accredited hospital serving Medicare patients that has serious problems identified, and be aware of efforts made by the Commission to assure that corrective actions are being taken.

HCFA's access to Joint Commission data and the opportunities it presents for federal intervention does, however, raise a significant issue: What should the roles of HCFA and the Joint Commission be in assuring that hospitals serving Medicare patients can provide quality care, and how should those roles be played out?

Two existing situations illustrate why the roles of HCFA and the Joint Commission should be clarified.

-- First, HCFA has not clearly identified its Medicare conditions of participation within the Joint Commission standards. Further, HCFA has not developed a usable guideline to determine whether the findings in the Commission survey reports relate to Medicare conditions of participation. As a result, HCFA does

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[1]Conditions of participation are health, safety, and quality standards which were developed to help HCFA assure that hospitals participating in the Medicare program are capable of providing quality care. There are 20 conditions prescribed in the Code of Federal Regulations relating to such areas as quality assurance, nursing services, and infection control.

not know whether accredited hospitals are capable of providing high-quality health care.

-- Second, the Joint Commission process for following up on corrective actions taken by hospitals in which problems have been identified takes much longer than HCFA believes is appropriate. As a result, HCFA does not know whether serious problems in hospitals serving Medicare patients are being corrected promptly.

HISTORICAL PERSPECTIVE ON THE ROLES OF THE JOINT COMMISSION AND HCFA

To provide a better understanding of the current relationship between HCFA and the Joint Commission, a quick review of the legislative history regarding Medicare certification of hospitals is in order.

Under the Medicare law adopted in 1965, the Joint Commission's accreditation of hospitals providing care to Medicare patients was to serve as evidence that hospitals were also in compliance with Medicare conditions of participation.[2] The Commission's accreditation process was not subject to federal review. Also, the Commission's survey reports were confidential and available only to its personnel and officials associated with the concerned hospitals. Further, conditions of participation established by the Secretary of HHS could be no more stringent than related Joint Commission standards.

The Medicare legislation drew criticism in two areas. First, the federal government was unable to determine the extent to which specific deficiencies existed in the majority of hospitals participating in Medicare. Second, the law permitted a private organization to develop hospital standards for Medicare.

In 1972, the Congress amended the 1965 legislation and required HHS to review hospitals accredited by the Joint Commission to validate the Commission's accreditation process. HHS was also given authority to develop or modify conditions of participation if it determines that existing requirements are inadequate. Late last year, the Congress enacted P.L. 101-239, which gives HCFA access to any Joint Commission data relating to Commission surveys of hospitals serving Medicare patients.

MEDICARE CONDITIONS OF PARTICIPATION NEED TO BE CLEARLY IDENTIFIED IN JOINT COMMISSION STANDARDS

As we reported to you last week, HCFA analysts often find differences in the problems identified at hospitals by state survey agencies and the Joint Commission.[3] This does not mean, however, that there are significant problems in the Commission's accreditation process. State agency survey findings relate to problems involving Medicare conditions of participation. Joint Commission survey reports identify problems in terms of Commission standards that are not being adhered to. But the two sets of criteria are different, and there is no means to easily identify which Medicare conditions of participation relate to specific Commission standards. As a result, the significance and causes of differences in survey finding are difficult for HCFA analysts to assess.

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[2]The Medicare law also required hospitals to have effective internal utilization review processes.

[3]Health Care: Criteria Used to Evaluate Hospital Accreditation Process Need Reevaluation (GAO/HRD-90-89, June 11, 1990).

Before Joint Commission survey results can be meaningfully interpreted by HCFA, a connection must be made between the Commission's findings and applicable Medicare conditions of participation. To do this, a comprehensive and usable guideline (crosswalk) is needed to establish a direct relationship between each Medicare condition and the comparable Commission standards. We understand that HCFA and the Commission are working to develop such a crosswalk. We must await the outcome of this effort to see how effective it will be.

CORRECTIVE ACTIONS ON PROBLEMS IDENTIFIED BY THE JOINT COMMISSION NEED TO BE MORE TIMELY

After accreditation surveys have been completed, the Joint Commission often takes up to a year to conduct its analyses and follow-up of survey findings. As a result, there is no assurance that significant problems identified by the Commission are being corrected promptly. In contrast, for hospitals outside the Commission's accreditation process, HCFA generally takes about 40 days to follow up on problems identified by state survey agencies.

From July 1, 1989 to April 23, 1990, the Joint Commission identified 28 hospitals that had serious problems and were in jeopardy of losing their accreditation. The Commission gave these hospitals what is called conditional accreditation. But these problems were not new. In 25 of the 28 hospitals, several problems cited in 1989 surveys were also present in 1986, when previous accreditation surveys were performed. For example, in 1989, Joint Commission surveyors reported that one hospital did not have a system in place to monitor whether patients with bloodstream infections received antibiotics. As a result, physician surveyors reported that needless deaths were possible. In 1986, the same problem was cited and the same conclusion reached.

The Joint Commission's follow-up of problems identified in surveys conducted in 1986 was slow. In fact, it did not follow up on most of the problems until late 1987 and early 1988. Further, it did not notify the affected hospitals of the results of the follow-up actions until 1989. Since the next scheduled accreditation surveys at most of these hospitals were only a few months away, the Joint Commission deferred taking actions on their accreditation status until completion of the 1989 surveys.

The timeliness problem encountered could recur in 1989. The Joint Commission took from 3 to 6 months to analyze survey data before it notified any of the 28 hospitals that they were about to receive a conditional accreditation. Each hospital was then given time to submit a corrective action plan. As of April 23, 1990, the Commission had scheduled only 2 hospitals for follow-up. These are scheduled within 6 months from the date that the hospitals' corrective actions were approved. The first follow-up is scheduled for July 1, 1990.

Until recently, HCFA was not aware of how long the Joint Commission took to follow up on these hospitals' corrective actions. Further, it did not know that the Commission decided to defer action on these hospitals' accreditation status until after the 1989 surveys had been completed. The President of the Joint Commission told us that the Commission allows longer time frames for follow-up actions so that hospitals can develop sufficient documentation to show that they have corrected identified problems. The Director of HCFA's Health Standards and Quality Bureau informed us that the Joint Commission's time frame of up to 1 year to analyze and follow up on problems is unacceptable.

CONCLUSION

Mr. Chairman and Subcommittee Members, HCFA needs to be sure that hospitals serving Medicare patients are capable of providing

high-quality care. At present, HCFA does not have that assurance because its efforts to validate the Joint Commission's accreditation process are hampered by the problems we have discussed today. Moreover, HCFA is unsure of the extent of its authority to require the Commission to alter its accreditation process to meet HCFA's needs.

We believe that HCFA should attempt to guide the Joint Commission's activities to assure that hospitals meet Medicare requirements. Specifically, HCFA and the Commission need to work together to assure that Commission standards relating to Medicare conditions of participation are identified and that Commission survey reports can be used to determine whether hospitals are out of compliance with Medicare conditions of participation. Further, HCFA and the Joint Commission should reach a mutually satisfactory solution on the best way to assure that (1) hospitals promptly correct problems the Commission identifies that relate to Medicare conditions of participation and (2) HCFA is quickly informed of these actions.

If HCFA and the Joint Commission cannot agree on these issues, alternatives to HCFA's reliance on the present system of Commission accreditation can be considered. Options include (1) establishing an organization within HCFA to conduct hospital surveys, (2) contracting with state agencies to conduct all hospital surveys, and (3) contracting with private organizations other than the Joint Commission to perform hospital surveys under the auspices of HCFA. Each of these potential alternatives would be time consuming and expensive to establish, and would likely require changes to existing Medicare legislation.

None of the above alternatives appears to be clearly superior to the current system if it were operating well. Thus, we believe that if HCFA finds that it cannot make the system work effectively within its existing legislative authority, the Congress should consider providing HCFA the authority it requires to be sure that the Joint Commission's accreditation process is effectively serving the Medicare population.

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This concludes my prepared statement. We will be pleased to respond to your questions.

Chairman STARK. Thank you.

I am going to talk about crosswalk a minute. For our guests, if they have no more idea what crosswalk is than I do, let me summarize my understanding.

David, tell me if I am way off.

It is my understanding that the joint commission has a set of standards, goals, and guidelines to reach a kind of target. It is like being an Eagle Scout. You work your way up through the ladder. You want to, as the ultimate, excel in all of these 2,000 categories.

HCFA, on the other hand, has a set of 19 or 20 minimum standards. If you go below those or, in some cases, if you don't comply with one of them—for example, antidumping, you are out of the game.

One is a quality enhancement program and the other is kind of a set of minimum standards.

Then States may have another different set of criteria which really are not on the table today.

So is that a fair assumption of where we are?

Mr. BAINE. I believe that is a fair assumption of where we are.

Chairman STARK. Crosswalk, as we will hear, is the idea that somehow you have to take the joint commission's goal-oriented

rules and conditions, and translate those so that they somehow relate to these minimum standards that HCFA has. You can get the joint commission to change theirs or HCFA to change theirs, but that we are dealing here with an Apple Computer on one side and an IBM on the other. We can't get the data to show up on each other's screens in the same format. Is that a fair layman's assumption of where we are?

Mr. BAINE. Yes, sir.

The point we tried to make in the report we just issued to you is that we believe that there needs to be a way to walk from the conditions of participation back to the commission's standards. The reason this is important is because HCFA is required by the Medicare legislation to validate the joint commission process.

At the present time, the way HCFA does not produce a meaningful validation. That is one reason for the crosswalk.

The second reason that we mentioned the crosswalk is that as time goes on, and HCFA receives the information from the joint commission related to its set of standards, HCFA needs to be able to translate that into what it means for the Medicare program.

I would like to say one other thing about the crosswalk.

Chairman STARK. Go ahead, please.

Mr. BAINE. When we proposed the crosswalk, there was some discussion at the private session this morning that there is more to it than this. We more than agree with that process or with that comment. Our attempt was to try to initiate something because up until the time we took a look at this at your request, there really was not an awful lot going on.

Chairman STARK. There are about 6,000 hospitals in the country. Most all of them qualify for Medicare—right?

Mr. BAINE. Yes, sir.

Chairman STARK. Give or take a couple hundred?

Mr. BAINE. Yes, sir.

Chairman STARK. Most of them belong to the joint commission, also.

Roughly, how many employees does the joint commission have? Anybody want to guess?

Mr. BAINE. I don't know, sir.

Chairman STARK. Dr. O'Leary, do you want to hold up fingers?

Dr. O'LEARY. 400 full-time employees, about 500 surveyors in the field.

Chairman STARK. Some 900 altogether?

People in the field are part time?

Dr. O'LEARY. Can be consultants. Some are part time. A small number are full time.

Chairman STARK. Is that enough?

Dr. O'LEARY. Today, yes.

Chairman STARK. Roughly, how many people in HCFA are responsible for surveying, inspecting or investigating?

Mr. BAINE. I am not sure. The reason I am not sure is because HCFA contracts with State survey agencies, to actually conduct the surveys.

The number of people that HCFA has available to analyze the information is not great.

Chairman STARK. Roughly, how many?

Not more than 100?

Mr. BAINE. Certainly not more than 50.

Chairman STARK. Ten?

Mr. BAINE. Mr. Morford says five.

Chairman STARK. Five.

Mr. BAINE. That is five in the central office. There are regional office people.

Chairman STARK. So there are 20 people in management. They are responsible for somehow coordinating whatever information they may or may not get from the joint commission?

Mr. BAINE. Right.

Chairman STARK. Getting requests or translating that for 50 various States who, for the most part, use State employees and a State system to do our followup work, is that about the way the system works?

Mr. BAINE. Yes, sir.

Chairman STARK. I am going to give you the Stark standards here: clean; no shakey-handed surgeons; no blood with AIDS in it. The kind of thing that would not scare me.

I think as Dr. O'Leary defined it this morning, you wouldn't send your mother to that hospital unless you were very mad at her. That is my standard.

Is there a wide variety among States as to how good they are at identifying the hospital I wouldn't want to recommend to my friends and relatives?

Mr. BAINE. As part of our ongoing review—not that which was reported to you last week—we did work with the State survey agencies and work at the HCFA regional offices. The short answer to your question is, yes, there is a lot of inconsistency among the State survey agencies.

Chairman STARK. HCFA takes the States' findings as conclusive? In other words, if the State will license them and let them operate, we will continue to pay under Medicare?

Mr. BAINE. Generally, that is right.

Chairman STARK. Here is what I am getting at. There is a hospital in my district called Hayward. It failed to hit a standard for the joint commission.

I will ask Dr. O'Leary about that later so I don't label it wrong.

It seems to me, if the requirement wasn't met and then, having been acknowledged, wasn't corrected, people should be cautious about going there.

It turns out, though, that the State still let it operate. It still qualified for Medicare.

Now, these deficiencies may have been corrected. I may be talking about something that happened a year ago. But at some point in the past couple of years this was the situation.

To my knowledge, the hospital has never been kicked out of Medicare.

In your opinion, is there any reason that that should happen?

It seems to me that, as I've identified the problem, we ought to be able to deal with that. Is there a system now that will let us deal with that?

Mr. BAINE. I believe the way the system is now, we cannot deal with that.

Chairman STARK. So it is not anybody's fault?

Mr. BAINE. That is right. That is why it is important to square up the conditions of participation with the joint commission's standards so people understand what is and is not under both programs.

Chairman STARK. We have three groups here. We have HCFA, the joint commission, and the States. Is there any one of those three groups that you would make the model and then have the others conform to their system? Shall we start with the States because they are there and we can have an effect on them, and then try to get the joint commission and HCFA to adjust?

Shall we say to the joint commission, you keep doing what you are doing and we will try to fit in your mold? Or should we do HCFA's thing and try to make everybody else march to our drummer?

Or do we have to change to a whole new system?

Mr. BAINE. I don't believe we have to change to a whole new system. We would not advocate that. With regard to whether we ought to take one or the other, it has been pointed out to us by Dr. O'Leary and others there is probably not a gold standard for hospital standards.

So whose do you take? That is kind of dependent upon the purpose you are taking them for.

That is why we think that the notion of some sort of a way to walk from the conditions of participation to the commission's standards and back and forth should not be all that difficult. It is a legitimate first step toward making the joint commission process really an interactive process with the Medicare process.

Chairman STARK. Hospitals are a lot of things. Really, hospitals, I suppose, can get accredited with just some nurses, rooms, beds and no medical staff.

Maybe not. Ala-bates used to be that way. Ala-bates was a rooming house. It had a bunch of nurses there. It had a place to operate. It had a medical staff, but they didn't have anybody on their payroll. It was just a place.

It is a lot different some 30-odd years later. There is a medical staff. There is management and then there is all these labs and other things that they do.

Do you approach this in its pieces? Does the hospital have to all function together?

I gather most of the procedures say if any one part is bad, the whole system fails; right?

Dr. O'LEARY. Right. That is right.

Mr. MOODY. Mr. Chairman, what does he mean by that, if one part is bad, the whole system fails?

Chairman STARK. Let's say that you have a hospital with the super-stars of surgery on its staff, but the housekeeping department is crummy. Say you have a lot of dirty hallways and the kitchen isn't clean. The staff doesn't wash its hands.

Now, do you shut it down?

On the other hand, maybe it has, as you have in Milwaukee's hospitals, a maternity hospital, a separate little pavilion. If that is not good, can you close that down and say no more maternity cases?

I am trying to find out if, in general, you take the hospital as a total operation.

Mr. BAINE. It is my understanding, Chairman Stark, in general the joint commission does take the hospital as a total entity.

Chairman STARK. We will get to that.

Let me say it this way: I would be concerned about the minimum standards. It would seem to me while it would be very nice for us to educate hospitals and help them get two stars instead of one star, that we have to assume across the country a certain minimum level below which nobody goes, and anything above that is nice.

From the standpoint of dealing with Federal laws and Federal payments, we ought to have some kind of a rock-bottom standard. We wish it could be higher, but we may have to tolerate it.

We can't have a different standard for California than for New York.

So I am going to just suggest to you that we ought to be very clear about what HCFA's minimum standards are.

Mr. BAINE. Yes, sir.

Chairman STARK. We don't have that very clearly defined right now; is that correct?

Mr. BAINE. That is exactly correct.

Chairman STARK. So, before I can get Dr. O'Leary to change and before I can require the States to provide this information, it would seem we have to establish within HCFA some sort of minimum standard. Is that going to be tough to define?

Mr. BAINE. Medicare conditions participation, as we understand it, are supposed to represent the minimum standards. I don't think there is any question that as the medical care delivery system has become more sophisticated, there will be a need, an ongoing need to change the standards, to keep up with the delivery system on both sides of the house, and then to be able to walk from one to the other so folks would understand.

Chairman STARK. My concern is that the people who are responsible for HCFA ought to define HCFA's level of minimum standards. We are going to have to start somewhere, so I can't worry about the States.

I can't worry about the joint commission. I can applaud them, but our responsibility here under the Medicare law is to have a more clearly defined minimum standard.

Mr. BAINE. Or perhaps one that is more up-to-date with the way health care is being delivered in this country now.

Chairman STARK. OK. Now, could GAO determine a standard like that? OTA? ProPAC?

Where do I go to say what is the right standard? HCFA? You? OTA? ProPAC? Who?

Mr. BAINE. I can say this: if we were to be involved in that process we would have to have a lot of help from folks who know what minimum standards should be clinically.

Chairman STARK. Is there anyone in the government now that has the staff and the talent and the expertise to generate that standard and put it in place?

I am sure there are people outside. Do we have anybody now? OTA?

I am asking for an opinion.

Mr. BAINE. HCFA, in fact, has people who have done the conditions of participation, and——

Chairman STARK. They could call on OTA, ProPAC?

Mr. BAINE. Outside consultants or whatever.

Chairman STARK. In other words, that——

Mr. BAINE. That is something that needs to be done, sir.

Mr. MOODY. Mr. Chairman, may I ask a question?

Chairman STARK. Hop right in.

Mr. MOODY. Your report indicates wide variations in the quality of State surveys for Medicare conditions of participation. Does HCFA itself do any look behind surveys either to review the actual results of the State's survey or to directly survey the hospital?

Does it always rely 100 percent on nothing but the State survey?

Mr. BAINE. Generally, for accredited hospitals, they do not, sir.

For hospitals that choose not to be accredited by the joint commission State survey agencies, HCFA will look behind the State survey agency information.

Mr. MOODY. Choose not to be. You mean are not JCAHO members?

Mr. BAINE. Yes. That choose not to be accredited by the joint commission.

Mr. MOODY. There are some that choose not to be accredited?

Mr. BAINE. That is right.

Mr. MOODY. So HCFA does not rely strictly on the States, is that right? Is that what you are saying?

Mr. BAINE. HCFA, as I understand it, does a small number of look behinds, as you said, of the State agency surveys.

Mr. MOODY. Only where there is no JCAHO?

Mr. BAINE. Right.

Mr. MOODY. When they do that, do they find wide variations in the quality of the State surveys? Do you happen to know that?

Mr. BAINE. Mary Ann tells me that when they do some of the look-behinds, they find variations between their own findings and the State findings. As part of the work we are doing for Chairman Stark, we have noted that there are some inconsistencies—a fair amount of inconsistencies—among the State surveys.

We noted that ourselves. We will be reporting to Chairman Stark on that later.

Mr. MOODY. I see. Thank you.

Is it in the nature of different base lines that you are comparing? Is it apples to oranges or is it from looking at the same pair of apples that you get different results?

Mr. BAINE. The latter, sir.

Mr. MOODY. I see.

Thank you very much.

Chairman STARK. Thank you.

I hope you can hang around for awhile. We have spent the morning with you fairly informally. I know, as the other witnesses are with us, we may want to refer to you, to your staff, or the others.

If it is possible, could somebody stay with us for awhile? It would be appreciated.

I appreciate your work in this area. It has been very helpful to us.

Mr. BAINE. Thank you. We will be glad to stay as long as you like.

Chairman STARK. Thanks.

Dr. Wilensky was with us all morning and had previous engagements. Due to the schedule of the House, we had to change the timing of these hearings. She is being represented for the rest of the day by Thomas Morford, Director of Health Standards and Quality, accompanied by William Smith, Director of the Office of Survey and Certification.

Dr. Wilensky's entire statement will appear in the record without objection.

Tom, would you like to pick up from where we were this morning? I am sure the record will look very consistent because we will have Gail's complete statement in there.

Mr. Moody, feel free to interrupt at any point. Maybe you could go on. I am sure you gather what our worries are.

Just kind of enlighten us as you will.

STATEMENT OF GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, AS PRESENTED BY THOMAS G. MORFORD, DIRECTOR, HEALTH STANDARDS AND QUALITY BUREAU, ACCOMPANIED BY WAYNE SMITH, PH.D., DIRECTOR, OFFICE OF SURVEY AND CERTIFICATION

Mr. MORFORD. I will pick up on some of the points Dr. Wilensky made this morning. First of all, I will discuss the issue of equivalency of the joint commission standards versus HCFA's conditions of participation.

Very frankly, you will never see a line-to-line equivalency between Government requirements versus those of any private sector organizations. We face the same issue in potential deeming of clinical laboratories, home health care agencies, right down the line.

The real issue is trying to look at the total package, figuring out the general areas of equivalency and making sure when a private accrediting organization finds something, that it generally matches our conditions of participation.

We do have a crosswalk. I would, frankly, tell you the crosswalk needs updating and we are in the process of doing that.

I think the generic issue for deemed status—again, whether this is the joint commission or anybody else——

Chairman STARK. A deemed status means you get paid to be a Medicare hospital?

Mr. MORFORD. To be clear, a deemed status means those facilities—in this case hospitals—that are accredited, can participate in Medicare by virtue of that accreditation.

Chairman STARK. Could they participate under any other conditions?

Mr. MORFORD. No, sir. The only deemed status that exists today under the statute is for the joint commission. We are considering other organizations.

Congress liberalized the deemed status provisions a few years ago. We are looking at a number of organizations, for example, home health agencies. The clinical laboratory improvement amend-

ments very specifically directed us to look at deemed status for organizations that are accredited laboratories.

At this time, deemed status is granted only for joint commission hospitals.

Our concern is with processes in total and for making sure that what the joint commission finds is accurate on the first level.

Second, that based upon those decisions, they take the right actions in accordance with their own rules, to the extent that they are comparable with ours. A surveyor goes into a hospital. The surveyor finds the problems that exist. We do validation surveys to see if their findings match ours.

Chairman STARK. Let me back up to where we were a minute ago.

Are you convinced that Medicare conditions regardless of how we translate them to somebody else's conditions, are clearly established at the proper levels so I should feel comfortable going into any of these hospitals? Or do we have to start within HCFA and redesign our base?

Mr. MORFORD. I don't think we need to redesign the base. The issue is updating. Obviously, health care changes in the United States, and we as the Government, as large and ponderous as we are with the rulemaking processes and so forth, frankly, have difficulties keeping up with the state of the art.

I think in the case of the conditions for hospitals, they were most recently revised in 1986 and they set a very clear minimum benchmark. If you fall below those conditions, you are in trouble. You ought to be.

Chairman STARK. We went into great depth with the problem of another hospital in California this morning. You heard all the problems relayed.

I gather that that hospital, for whatever reason, is now clearing your hurdle; right? You are paying it?

Mr. MORFORD. Again, I apologize for not being prepared to discuss any hospital. I assume from the discussion that they are indeed in Medicare.

Chairman STARK. You wouldn't go to that hospital after hearing what you heard this morning?

Mr. MORFORD. Not after hearing what I heard this morning, but I guess I would caution——

Chairman STARK. There might be another side to that story.

Mr. MORFORD. No. The issue, it seems to me, is what is the situation in the hospital, as determined from the latest date we can obtain.

Chairman STARK. I understand that. We have a time lag. people can improve and change.

I guess what I am saying is—and this is what worries me—that minimum standards somehow aren't so clearly defined or aren't at a level where we are sorting out or eliminating those institutions that you and I agree we would be nervous about.

If that is one of the things we have to change, then we can get at it, I think. I am not trying to push you into a corner here, but what I am hearing is we ought to start there. Maybe we ought to start someplace else.

Please tell us.

Mr. MORFORD. To be absolutely candid, I think the first level is do you scrape by, or are you one of those hospitals that are real good. You meet everything. You excel at everything.

The issue of concern is one that is relative. I think that was Dr. Wilensky's point this morning about disclosure. I find it extremely interesting and will give you a parallel case in nursing homes.

A nursing home makes it. Gets certified. We look at a report. We say, well, this place had a problem with nurses, over time. The public ought to know that and factor that into their thinking. That is why disclosure is so important. I am satisfied the minimum hospital standards are appropriate.

If a hospital makes it, we should continue to pay them. I am not saying you shouldn't be concerned.

But you have to draw a line somewhere and say, well, when is it bad enough that the Federal Government will say we are not going to pay for our Medicare beneficiaries.

Chairman STARK. How many hospitals in the last year or so have we really thrown out of the Medicare program?

Mr. MORFORD. In the last year-and-a-half, we have thrown out—terminated—about 20 hospitals.

Chairman STARK. Out of 6,000?

Mr. MORFORD. Roughly 20 hospitals out of 6,000.

Chairman STARK. Don't you suspect that there are more problems out there than that?

Mr. MORFORD. I suspect there are all kinds of problems out there. The issue is how bad is it? I don't think the answer is terminating 200 hospitals. I think the answer is getting them to fix the problems.

Chairman STARK. In a sense, terminating is not necessary—well, in some cases that financially might destroy them. Shouldn't we put up a sign saying Medicare patients not allowed?

Mr. MORFORD. I think that is the equivalent of termination, sir. When we put up that sign, that is pretty clear.

I agree with you. I think you are on target on this notion that people ought to be aware that there are various levels of problems in a hospital or maybe it has had a history of problems.

Chairman STARK. I can't understand that. You can. Dr. O'Leary can. But I figure it has a license in California, it must be OK. I am beginning to worry about that.

It is new, modern, a lot of Porches in the parking lot, which means the doctors are doing all right.

Mr. MORFORD. Hopefully, the patients are.

Chairman STARK. Yes. I would suppose if I went into Manhattan, probably one of the finest hospitals in Manhattan, I am guessing, might look scruffy to me by California standards because its physical plant might be pretty dilapidated as compared to the kind of campuses we have out there and still be an excellent hospital. So how do I know?

I guess what I am getting at is there ought to be a way that I can know.

Second, you ought to have a means by which the system can tell me that. I am not sure we have that yet. Maybe we do.

Mr. MORFORD. I am not sure we have it either. I am not sure that it is possible to have. I think in terms of public assurance—I don't

care if they meet Dennis O'Leary's standards or our standards—we will never have a guarantee care in this hospital is perfect.

You know some hospitals are better than others. You might feel more comfortable at Mass General than one of the hospitals in your own district.

Chairman STARK. Only if I can get in under an assumed name.

Mr. MORFORD. It has been said I can't have surgery anywhere in the United States either, but that is a secondary issue.

The real issue for us is at what level do you throw places out? The second level where I said I think you are on target is where your concerns ought to be in the various gradations.

Do we put a sign up? We have done surrogate measures for these kinds of things. We are going to require, under new law, nursing homes make the results of their last surveys public. That is great if you know what you are looking at. But you don't.

Chairman STARK. Nursing homes don't have the joint commission. Nursing homes rely almost entirely on the States.

Mr. MORFORD. Yes, but the generic issue you point out is the same one. There is a minimum standard that at some point a nursing home is in compliance.

It may still be in compliance with problems. Or it may have had a roller coaster career.

I think the only way to solve the problem—God knows we don't need more Federal regulations—things are complicated enough is through disclosure.

For example, we could disclose in an understandable way—and some of our critics will say we will never be able to do that although we try—what the recent history has been at a nursing home.

A nursing home could disclose survey results so people can understand—OK, this place is in compliance; yes, it has a license and it is certified and it is accredited; but, gee, look at this area, they have had a problem there.

Chairman STARK. What if I put the burden on my doctor's back? He is the guy that sends me to the hospital. I don't know what the hospital does. He or she ought to. That is their workshop.

What if we said, doc, you send somebody to a substandard hospital, and you are out of the game or you have the liability. I gather it would put some of them out of business, maybe.

Mr. MORFORD. It would probably put some of them out of business, but there are several hundred thousand doctors out there. I am not sure how we would even begin to design a system to address individual physician accountability versus defining a substandard hospital. That was really the issue you raised in terms of the gradations.

We tried surrogate measures. We tried to educate consumers in other areas, tried to inform people to ask their doctor the question.

Chairman STARK. I gave you a good example. In Madrid, there is a bullfight ring. There is a little operating arena just off the edge of the ring. It has got flies in it.

The last guy tracked through with manure on his boots. There is a dirty sink in the corner. If you got gored by one of those bulls, it meets the standards because that is all there is. If it is all a doctor has, I guess that is what he has to use.

Mr. MORFORD. That is one of the problems. I can give you another story of a rural hospital in Texas. We threatened termination because there was manure in the emergency room. As the good folks in Texas pointed out, the reason it's there is because they are bringing in the farmhands. They have manure on their boots. That was perfectly fine. That was the only hospital within 150 to 200 miles.

Chairman STARK. I will say this for Dr. O'Leary.

Do you have different levels of hospitals? Or is a hospital a hospital as far as HCFA is concerned?

Mr. MORFORD. Other than a district hospital, a hospital is a hospital.

Chairman STARK. Ought we to have not only minimum standards, but also different classes of hospitals? Would that serve the public?

You have to tell me whether that is a risky hospital for you to go to.

Now, how risky? Is it so risky that I ought not to go at all and stay home and bleed?

Mr. MORFORD. I really have a problem with the notion of the Federal Government setting up gradations of hospitals. I think, frankly, the first problem is I don't know how to do it. We can convene experiments, establish gradations. I think the fundamental gradation ought to be against the minimum standards and whether you are in compliance or not in compliance and being able to somehow post or disclose to the public the history of that facility.

What did it show on the last survey? Then the public can at least be more informed. Then generally what you find is the press plays a greater role. Look at the last time somebody was in this hospital, they were out of compliance in the following areas.

That is a form of public education. It is not perfect. I realize it doesn't hit the bull's eye the way you directed it.

My real concern is a good notion gets into such heaps of Federal regulation, minutia, judicial systems, we will never bring it off as we would all like to see.

I think the best answer is the disclosure of the survey results against the minimum standards and the disclosure of the joint commission results.

Chairman STARK. Let me ask you a couple of questions. If you don't know the answer now, let me know after the hearing.

Roughly, how many hospitals in the last year have received 90-day termination notices?

Mr. MORFORD. I really do not know. We don't track the notices. We track the terminations. I will try to get you an estimate of that for the record, sir.

[The following was subsequently received:]

90-DAY TERMINATION NOTICES

A total of 289 hospitals received 90-day termination notices in the past year. Of these, 182 were Joint Commission accredited hospitals and 107 were nonaccredited hospitals.

Chairman STARK. I would like to know in terms of Hayward Hospital—maybe you do know, or Dr. O'Leary does—how soon after

they lost their accreditation was California directed to survey the hospital?

What was the time lag there? Do you know that?

Mr. MORFORD. I don't know for that specific hospital. I can tell you generically as soon as we are notified by the joint commission, we instruct the State survey agency.

Chairman STARK. As far as your office is concerned——

Mr. MORFORD. As soon as we know it happens, it is a routine processing matter. I will have the answer for you on the specifics of that hospital.

[The following was subsequently received:]

HAYWARD VESPER HOSPITAL ACCREDITATION LOSS

Hayward Vesper Hospital voluntarily withdrew from the Medicare program and ceased operations on July 31, 1988. Therefore, the hospital did not have a Medicare survey. The hospital did not inform the Joint Commission that it was withdrawing from the Medicare program or of its closing. Since the Joint Commission did not know that the hospital had ceased operation, it sent a request for a recertification survey in 1990. After receiving no reply, the Joint Commission unaccredited the hospital.

NOTIFICATION BY THE JOINT COMMISSION TO HCFA

Under the current agreement, the Joint Commission forwards immediately to HCFA's central office a copy of its letter to the hospital giving the notice of loss of accreditation. In the past, the Joint Commission provided HCFA with this information on a monthly basis.

As soon as HCFA learns that a hospital has lost its Joint Commission accreditation, HCFA calls the regional office. The regional office is instructed to contact the hospital immediately to determine whether the hospital wishes to continue its participation in the Medicare program. If the hospital does not wish to continue its participation, the hospital is terminated from the Medicare program.

In addition, loss of accreditation affects the hospital's continued participation in the Medicaid program. In order to continue participating in both Medicare and Medicaid, the hospital would have to immediately correct deficiencies and be subjected to the State's Medicare survey and certification procedures.

Chairman STARK. Mr. Moody.

Mr. MOODY. Just one brief question. In the meeting this morning, you probably heard us discuss this problem. If a hospital is not accredited for Medicare, a patient is so informed. Presumably when the patient arrives, he is asked what insurance he has. If he says I have Medicare, the hospital says they don't have Medicare accreditation.

What about an emergency situation where there is no time to ask those questions? Who actually picks up the bill? Does Medicare pick up the bill?

Mr. MORFORD. I would have to check for the record.

My recollection is we have special provisions in emergency cases. Under the antidumping provisions, we expect that patient to be treated at that hospital.

I will get you the detailed answer for the record.

[The following was subsequently received:]

PAYMENT FOR EMERGENCY SERVICES

Section 1814(c)(d)(1) of the Social Security Act authorizes the Health Care Financing Administration to reimburse a nonparticipating hospital for emergency services received by a Medicare beneficiary. The nonparticipating hospital is reimbursed for services if: The diagnosis is considered an emergency condition, as based on physi-

cian assessment of the patient's condition; and the availability of suitable transportation contraindicates taking the time to arrange transportation to a participating hospital.

Reimbursement for services in a nonparticipating hospital is limited to the period of the beneficiaries confinement during which only inpatient hospital services necessary to prevent death or serious impairment of health were required.

Mr. MOODY. Thank you.

Chairman STARK. Mr. Gradison wanted me to see if I could follow up on this area a little bit.

Dr. Wilensky's testimony states that you saw an increase in deficiencies in 1988. I guess the basis is that one-third of the hospitals that you reviewed—I don't know whether it is one-third of all of them or the ones you reviewed—were out of compliance and the joint commission only found 7 percent out of compliance.

There seems to be a discrepancy there. Can you clarify that for us?

Mr. MORFORD. In our review, the reason we first showed concern, we did find a significant number of those hospitals, in our review sample—which was fairly low—maybe that is the key point it was fairly low—which we considered serious, that is, at a deficiency level.

Our first reaction was to try to proceed in an orderly fashion and to direct the increase in the number of validation surveys.

So we really had statistical validity. I think the most important point is that, coupled with the continued disclosure by the joint commission to us of their followup, the issue isn't simply what you found.

The issue is making sure you did something based on what you found. I keep coming back to that point. It seems to me that that is the critical issue with our monitoring.

Chairman STARK. This is cutting both ways. In theory, the joint commission is trying to validate that a hospital meets an optimal standard.

You are trying to verify a minimum standard. OK.

Now we are hearing cases here both ways. The hospital in my district didn't meet the joint commission's optimal standards and they were decertified, in a sense, or it lapsed.

Yet, you let them keep operating. On the other hand, you found some that didn't meet your minimal standard and the joint commission gave them accreditation. Now, I am confused. Can you shed some light on that?

Mr. MORFORD. I will try.

Chairman STARK. OK.

Mr. MORFORD. The joint commission, let's say, nonaccredits a hospital. The State goes in and looks at it. The State may say, "you have all these problems." Now, again, there are rules under the statutes and regulations that emanate from those statutes that say this place has to have a chance to fix itself up to that minimum standard. That is why we send so many terminations——

Chairman STARK. Is that a Federal rule?

Mr. MORFORD. It is a Federal rule.

Chairman STARK. That they have to have a chance to comply?

Mr. MORFORD. Yes, sir. It is a Federal rule right out of the statute. Even in the cases where we define immediate and serious jeopardy, we have to allow the facility the time——

Chairman STARK. is that due to legislation?

Mr. MORFORD. It is out of the legislation, sir. The regulations follow that.

Chairman STARK. Are there people who would suggest that that ought to be changed?

Mr. MORFORD. Not really.

Chairman STARK. OK.

Mr. MORFORD. The game isn't to go out and close a bunch of hospitals. The game is to get them up to minimum standard.

A State agency goes in, finds a set of problems, let's say, they have a 90-day termination notice or 23 days. What we found even in egregious cases, and we call them success stories, is that there are those who accuse us of being afraid to terminate. But we do terminate hospitals. We have taken out some pretty large hospitals. We took out Cook County, Martin Luther King, Highland Hospital, Harlem Hospital, large urban institutions that obviously——

Chairman STARK. You guys don't care——

Mr. MORFORD. The efforts that the hospitals, particularly the community-owned, and the county-owned, the State-owned hospitals, have taken are fairly heroic measures.

Let me give you Martin Luther King as an example why termination can be success stories.

We went in there, found no quality assurance, egregious shortages in nurse staffing. We sent them a termination notice. The county got mobilized. They appropriated considerable money.

They got temporary help. They got consultative help. They fixed that place up.

Now, the question is, is it a five-star hospital? Well, I would frankly doubt it.

Does it meet minimum standards? Yes, I am convinced it does.

I would also be cautious, of course, given their past record. That is kind of the problem that can occur again. Going back to this issue of gradations and level of concern, we can inform the public, but we really cannot do, I think, much more in terms of that issue.

Now, the issue that you raised before about the joint commission's finding something and we go in and we don't find it. There are myriad issues. There are time frame issues. The joint commission may have been in there a couple of years before. We go in and find the situation has deteriorated, so on and so forth.

Again, I would have to look at the specific hospitals to give you the precise answer.

Our standards are clearly articulated as the minimum. I think it is fairly clear from, I think, a very aggressive enforcement posture, that if you don't meet them you are in serious trouble. We generally get people's attention quickly with the termination notice.

Chairman STARK. Would you agree with GAO, though, that we ought to look at HCFA's standards with the idea of updating them?

Mr. MORFORD. Yes, sure. We are always doing that. I guess I would take issue with GAO on both their notion of a crosswalk and their notion of the standards.

Sure, standards always need to be updated. As I said before, private sector organizations don't need to issue proposed rules, final rules, et cetera, to deal with everybody in the country who has a better idea.

They can go and pretty much set standards that are the state of the art.

That is a big encumbrance for the government. We will never match private sector standards vis-a-vis the state of the art.

That is why deeming in general terms is a fairly good notion.

Chairman STARK. What would you think if you let the public know? I am not sure how we could do that unless we really want to go all out and have some kind of an education program. Put your mom where she is going to be safe. Look for the eagle, don't go to a hospital that isn't approved by Uncle Sam.

That would take a lot of effort. It took a long time for the banks to sell that concept. It took about 1 year for us to destroy the public's faith in it. Is that what we ought to do? I don't care whose accreditation it is, whether it is the joint commission, or the States. I just want something.

I don't think the public has any idea. Hospital. That is all they see. They see a sign along the freeway. They say it has to be good, it will save us.

You and I suspect differently.

Now, in the District supplement of the Washington Post, there is a list called "Food Establishments Closed." You don't necessarily read it.

I bet you go to some of the same greasy spoons I do.

Maybe I don't want to know what is going on in the kitchen. I just want to chomp my cheeseburger and hope it has no cholesterol and no cockroaches.

The chances are that neither is true. This list let's the public know who and why and for how long a restaurant has been closed. Then the public can make their own decisions. The question is, how are we going to get this same thing across for hospitals?

Mr. MORFORD. Mr. Chairman, the honest answer is, I really do not know. The longer answer is that we have tried some things before. We released hospital mortality statistics, with a lot of controversy.

We released nursing home information, with a lot of controversy.

I think those are good public disclosures. We worked with organizations—particularly the AARP—in trying to disseminate this information, and get it into the newsletters people read. Even when we terminate a hospital, we put a notice in the paper.

Being a government, we go for the cheapest ad; we put it in the want ads. I am sure unless a reporter is following that, you are not going to know.

It is really a long process of public education, and I think, frankly, the more we put out there, the more use it will have, particularly to consumer advocates.

I mention, again, the AARP. When we first put out our nursing home release, we didn't get much response. The last time we released such information, the AARP sent it out in their newsletters. People became aware of where the information is available.

We have reams of information available, but it is generally useless to anybody who is unsophisticated in reading a Federal survey report form.

What good will that do you? You have to get it in English, in usable form, and work with people to get it distributed.

Chairman STARK. Also, at some point we have to say you are closed, too, don't we?

Mr. MORFORD. Very clearly. At some point you don't meet Federal standards. You are gone. It is that simple as far as we are concerned.

Chairman STARK. Thank you very much. I hope we can get on with this and that we can help you work out an improved system. How is that?

Mr. MORFORD. Thank you. We are anxious to continue work on that as well.

[The prepared statement follows:]

STATEMENT OF GAIL R. WILENSKY, PH.D.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Medicare hospital certification program and the role of the Joint Commission on Accreditation of Healthcare Organizations in that process. We recognize the importance of ensuring that accredited hospitals meet the quality standards required by Medicare.

The Health Care Financing Administration is actively evaluating the performance of the hospitals accredited by the Joint Commission. Until recently, however, the law provided for only limited oversight of the Joint Commission accreditation process. OBRA 89 expands our legislative authority to better monitor the Joint Commission's process. Let me describe our activities to validate that accredited hospitals do meet Medicare quality standards.

BACKGROUND

Hospitals accredited by the Joint Commission are deemed by law to meet the Medicare standards or, as we call them, the conditions of participation. These hospitals are not subject to annual State agency inspections. Instead, the Joint Commission surveys these hospitals every three years.

The Joint Commission accredits approximately 5,200 hospitals. By far the largest majority, 93 percent, receive full accreditation for a three year period. Most of these hospitals receive recommendations to correct minor deficiencies. About seven percent of the hospitals receive a conditional accreditation which will be withdrawn for failure to correct significant deficiencies. The most recent data available to us indicate that only 21 hospitals were denied accreditation over a three year period.

It is important to recognize that the fundamental mission of the Joint Commission is an educational one. This is profoundly different than the enforcement objectives of a regulatory agency. The Joint Commission is a private organization which promotes improvements in hospital performance through compliance with professionally recognized health standards. By choice, a hospital pays a fee to the Joint Commission for its evaluation and accreditation.

Although the approach of the Joint Commission and Medicare differ, it remains our ultimate responsibility to ensure that hospitals comply with Federal requirements. Our primary tool to validate the Joint Commission's inspection findings has been through surveys conducted by State agencies.

VALIDATION PROCESS

The purpose of a validation survey is to assess the extent to which a Joint Commission accredited facility is in compliance with the Medicare conditions of participation. HCFA conducts validation surveys in a randomly selected sample of hospitals within 60 days of the Joint Commission inspection.

In 1988, we began to see an increase in the number of significant deficiencies found by State agencies which had not been identified by the Joint Commission. Our validation surveys found that one-third of the hospitals we reviewed were out of compliance with Medicare conditions of participation. We immediately withdrew deemed status from these hospitals and instituted State agency monitoring until corrections were accomplished. Thirteen hospitals were subsequently terminated from the Medicare program.

Our concern with the reliability of the Joint Commission's accreditation process led us to increase the validation surveys

to cover 5 percent of accredited hospitals. We have almost tripled our spending on State agency validation surveys to a total of $ 1.4 million for FY 1990. As a result of these efforts, 78 hospitals currently have lost their deemed status in the Medicare program and are being closely monitored by State agencies.

COMPLAINT SURVEYS

In addition to the validation surveys, the State agencies conduct surveys based on complaints about inappropriate treatment or inadequate quality of care. These surveys focus on those areas directly related to the complaint. If the State agency substantiates the complaint, the investigation is expanded to a full survey. In 1989, we conducted 577 surveys as a result of complaints and confirmed 69 problems. Deemed status was removed from these hospitals and State agencies are monitoring corrective actions. One hospital was terminated from the Medicare program.

MORTALITY INFORMATION SURVEYS

State agencies also survey hospitals, including accredited hospitals, which have demonstrated unexpected levels of patient mortality over a two year period. To date, 68 surveys have been conducted and 33 hospitals, 25 of which are accredited, are correcting identified problems.

OTHER VALIDATION ACTIVITIES

Our greater concern, however, is that we do not routinely receive sufficient data to determine the overall acceptability of the Joint Commission's process. We have requested information on a number of occasions. However, the Joint Commission has traditionally maintained that its accreditation information is confidential, and has been unwilling to release any information unless required by law.

Nevertheless, following a Congressional oversight hearing in 1988, the Joint Commission stated its willingness to work with us and increase the data it would share with HCFA. We immediately requested specific information from the Joint Commission. It was only last month that the Joint Commission provided us with a small portion of the information on eight conditional accreditations. Our preliminary review of this information has raised questions about the timeliness of the Joint Commission's process. We have already notified the Joint Commission of our concerns and questioned the comparability of the Joint Commission's accreditation with the Medicare certification program.

Specifically, the information from the conditional accreditations reveals that an average of 6 months elapsed between the date of survey and the Joint Commission's formal notification of deficiencies. The Joint Commission took an additional 3 months to determine the acceptability of the hospitals' corrective action plans. Hospitals then had 6 more months to correct these deficiencies before an on-site survey was conducted to evaluate the adequacy of the hospitals' corrective action.

This 15-month gap between the identification of significant problems and re-surveys is inconsistent with Medicare's enforcement program and presents a serious lapse in quality assurance.

Under Medicare, hospitals are terminated if they do not correct major deficiencies within 90 days from survey. Deficiencies posing an immediate and serious threat to patient health or safety must be corrected within 23 days or the hospital will be terminated from the Medicare program. Clearly, we cannot permit the Joint Commission to continue this pattern of assuring compliance. We are currently waiting for the Joint Commission's response on this issue.

OBRA 89

Problems with accredited hospitals can now be much more routinely identified as a result of provisions enacted in OBRA 89. The law makes provision for Medicare to receive accreditation information on a regular basis. Specifically:

- A hospital may be deemed to meet Medicare requirements only if the hospital authorizes the Joint Commission to release to the Secretary the most current accreditation surveys and other relevant material.

- The Joint Commission must release information to the Secretary regardless of whether the hospital is the subject of a validation survey.

- The Secretary may disclose surveys and related information to the extent that the information relates to an enforcement action taken.

- The Secretary may determine that a hospital does not meet Medicare conditions of participation based on information other than the validation survey.

We have identified the necessary accreditation material that will permit ongoing monitoring of the effectiveness of the Joint Commission's process. This includes:

- Date of survey;
- Accreditation decisions and deficiencies identified;
- Hospital corrective action plans and the date approved; and
- Date of follow-up visit and findings.

We are working with the Joint Commission so this information can be electronically transmitted. We are also developing a special computerized crosswalk to compare the Joint Commission's criteria to Medicare's standards. This will let us analyze the information promptly and efficiently and, if necessary, take action.

FUTURE OF DEEMING

We recognize the value that a deeming program, such as the Joint Commission's, contributes to Medicare. We also recognize our responsibilities to validate the comparability of such a program with Medicare's quality standards. Our increased validation activities will give us a firm basis for making decisions about the role of the Joint Commission in the Medicare certification program.

Over the course of the next year, we will evaluate enough survey information to draw a conclusion as to whether the Joint Commission's accreditation process provides a reasonable assurance that accredited hospitals comply with the Medicare standards. We are prepared to work with the Joint Commission to resolve problems, but we cannot allow Medicare standards to be compromised.

If Joint Commission accreditation does not provide the necessary quality assurances, we are prepared to look for alternatives.

CONCLUSION

We share the Joint Commission's goal to ensure that hospitals continue to provide high quality care. However, public accountability demands that we demonstrate that hospitals meet health and safety standards required by law. We intend to be aggressive in using our OBRA 89 authority to provide this quality assurance and we will take action to remedy any failure in the deeming process.

I will be happy to answer any questions you may have.

Chairman STARK. Our final witness is Dr. Dennis O'Leary, who is president of the Joint Commission on Accreditation of Healthcare Organizations, and he is accompanied by Kenneth Hermann, director of accreditation services, and Terrill Archambault, director, survey validation.

You have prepared testimony, which will appear in the record in its entirety, Dr. O'Leary.

I want to thank you and your organization for accommodating the subcommittee with the information we reviewed at great length this morning and with your staff's help in getting all of this to us.

I am going to let you summarize and I am going to ask you in addition to your prepared testimony, to suggest to us what we ought to do. You know the problem. It is where do I send my mom.

You have used the expression "buyer beware." How do we get from what all the witnesses know we ought to do to a system that will work pretty well for the public? That is all you have to tell us.

STATEMENT OF DENNIS S. O'LEARY, M.D., PRESIDENT, JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, ACCOMPANIED BY KENNETH HERMANN, PHARM.D., DIRECTOR, ACCREDITATION SERVICES, AND TERRILL ARCHAMBAULT, DIRECTOR, SURVEY VALIDATION

Dr. O'LEARY. Let me do my prepared remarks first.

I would like to request that the written testimony I prepared for the executive session this morning also be entered in the record.

We appreciate our opportunity to present our views on the GAO report concerning the oversight of the joint commission's hospital accreditation process that is being exercised by the Health Care Financing Administration.

We believe that the GAO report reflects a careful and thorough review of the relevant issues. Within the limits of our first-hand knowledge, we generally concur with the findings and analyses described in the report, and we endorse its two concluding recommendations.

The joint commission unequivocally supports the need for a substantive and meaningful Federal process for evaluating and validating joint commission accreditation decisions and findings. We believe this is to be in the interest of all of the involved parties and necessary to the assurance of public confidence in the nation's hospitals. The central issue is how such a process might be most effectively designed.

The current validation process was originally established through regulation in 1974 and has, in essence, remained unchanged in design since then. Over the years, the joint commission has worked in a cooperative fashion with HCFA to assist HCFA in meeting its oversight responsibilities. That cooperative relationship continues today.

It is important to note that the first Medicare conditions of participation were largely built from the then-existing joint commission standards, and it is a reasonable presumption that the respective survey processes, through which the standards and conditions were applied, were also generally parallel.

However, 16 years have passed, and not surprisingly, both the standards and conditions and their associated survey processes have evolved in different fashions. The question at hand is whether they are today sufficiently similar to assure comparability of the HCFA and joint commission evaluation processes. Unfortunately, that question cannot presently be answered with confidence.

Concern about potential divergences between joint commission standards and the Medicare conditions of participation led the joint commission in 1989 to perform a comparative crosswalk between the two sets of requirements that attempted to relate specific standards to specific conditions. This analysis was shared with HCFA. More recently, HCFA has undertaken a similar activity and has sought and now received our assessment of its analysis.

In our opinion, these initial crosswalk exercises are a necessary but not sufficient step toward achieving the broader objectives that we believe are integral to this public sector/private sector relationship. That is, there is a need not only to design a better validation process to assess comparability—a largely technical task—but also a need to identify and rectify any areas where the joint commission standards, in their practical application, are not adequately addressing the requirements articulated in the conditions.

This latter effort necessitates attention both to the content of present standards and conditions and to the manner in which hospitals are evaluated against these requirements through the respective survey processes.

The necessary work can, we believe, be completed within a reasonable timeframe. The joint commission is pledged to fully cooperate in such an effort.

We also believe it important to maintain a long view of these external evaluation activities. Hospitals have become increasingly complex organizations, and new areas of public interest relative to the performance of hospitals continue to arise.

Changes in joint commission standards and the conditions of participation since the Medicare program was enacted reflect, perhaps in different ways, these areas of public interest. We have every reason to believe that change will continue, if not accelerate, in the hospital field. Both HCFA and the joint commission must at least keep pace with, and hopefully anticipate, these changes.

Thus, an important additional objective is for the joint commission and HCFA to continually improve their respective evaluation processes in a parallel and comparable fashion.

As you are aware, the joint commission is in the midst of a major developmental effort to restructure its accreditation process. This project contemplates standards revisions to emphasize actual hospital performance, including the effective application of performance data related to patient outcomes. More recently, a major Institute of Medicine study has urged that the Medicare conditions be updated to reflect contemporary expectations of hospitals.

It is obviously important that these parallel initiatives receive timely and priority attention from HCFA and the joint commission and that the respective activities be carefully coordinated. If one of these initiatives moves forward and the other does not, we have concerns that this will place continuing Federal recognition of our accreditation process at risk. More importantly, we believe the

public interest will not be effectively served. We solicit the support of your committee in moving these initiatives forward.

We would like to extend our appreciation to the GAO staff for this thorough and objective study, and we would also like to thank you, Mr. Chairman, for occassioning this timely and appropriate examination of the Federal oversight of the joint commission's accreditation process. I would be pleased to respond to any questions you may have.

That is the text of my prepared remarks.

[The prepared statement and executive session statement follow:]

STATEMENT OF DENNIS S. O'LEARY, M.D., PRESIDENT, JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS

Mr. Chairman and members of the Committee, I am Dennis S. O'Leary, M.D., President of the Joint Commission on Accreditation of Healthcare Organizations. We appreciate the opportunity to present our views on the report of the U.S. General Accounting Office (hereinafter referred to as the GAO Report) concerning the oversight of the Joint Commission's hospital accreditation process that is being exercised by the Health Care Financing Administration (HCFA).

We believe that the GAO report reflects a careful and thorough review of the relevant issues. Within the limits of our first-hand knowledge, we generally concur with the findings and analyses described in the report, and we endorse its two concluding recommendations.

The Joint Commission unequivocally supports the need for a substantive and meaningful federal process for evaluating and validating Joint Commission accreditation decisions and findings. We believe this is to be in the interest of all of the involved parties and necessary to the assurance of public confidence in the nation's hospitals. The central issue is how such a process might be most effectively designed.

The current validation process was originally established through regulation in 1974 and has in essence remain unchanged in design since then. Over the years, the Joint Commission has worked in a cooperative fashion with HCFA to assist HCFA in meeting its oversight responsibilities. That cooperative relationship continues today.

It is important to note that the original underlying rationale for the present validation process probably had a sound basis in 1974. The first Medicare conditions of participation were largely built from the then-existing Joint Commission standards, and it is a reasonable presumption that the respective survey processes, through which the standards and conditions were applied, were also generally parallel.

However, sixteen years have passed, and not surprisingly, both the standards and conditions and their associated survey processes have evolved in different fashions. The question at hand is whether they are today sufficiently similar to assure comparability of the HCFA and Joint Commission evaluation processes. Unfortunately, that question cannot presently be answered with confidence.

As reflected in the GAO report, concern about potential divergences between Joint Commission standards and the Medicare conditions of participation led the Joint Commission in 1989 to perform a comparative crosswalk between the two sets of requirements that attempted to relate specific standards to specific conditions. This analysis was shared with HCFA. More recently, HCFA has undertaken a similar activity and has sought and now received our assessment of its analysis.

In our opinion, these initial crosswalk exercises are a necessary but not sufficient step towards achieving the broader objectives that we believe are integral to this public sector/private sector relationship. That is, there is a need not only to design a better validation process to assess comparability--a largely technical task--but also a need to identify and rectify any areas where the Joint Commission standards, in their practical application, are not adequately addressing the requirements articulated in the conditions of participation. As implied in the GAO report, this latter effort necessitates attention both to the content of present standards and conditions and to the manner in which hospitals are evaluated against these requirements through the respective survey processes.

Simply put, it is the functional translation of the standards and the conditions that really counts. This mandates, in our view, two sets of related comparisons and analyses--one between the respective contents of the standards and the conditions and one that evaluates the design and areas of emphasis in the respective survey processes. These analyses would seem to be essential to the design of a better validation process and can, we believe, be completed within a reasonable time frame. The Joint Commission is pledged to fully cooperate in such an effort.

We also believe it important to maintain a long view of these external evaluation activities. Hospitals have become increasingly complex organizations, and new areas of public interest relative to the performance of hospitals continue to arise. Changes in Joint Commission standards and the conditions of participation since the Medicare Program was enacted reflect, perhaps in different ways, these areas of public interest. We have every reason to believe that change will continue, if not accelerate, in the hospital field. Both HCFA and the Joint Commission must at least keep pace with, and hopefully anticipate, these changes.

Thus, an important additional objective is for the Joint Commission and HCFA to continually improve their respective evaluation processes in a parallel and comparable fashion. As you are aware, the Joint Commission is in the midst of a major developmental effort to restructure its accreditation process. This project contemplates standards revisions to emphasize actual hospital performance, including the effective application of performance data related to patient outcomes. More recently, a major Institute of Medicine study has urged that the Medicare conditions of participation be updated to reflect contemporary expectations of hospitals.

It is obviously important that these parallel initiatives receive priority attention from HCFA and the Joint Commission and that the respective activities be carefully coordinated. If one of these initiatives moves forward and the other does not, we have concerns that this will place continuing federal recognition of our accreditation process at risk. More importantly, we believe the public interest will not be effectively served. We solicit the support of your Committee in moving these initiatives forward.

We would like to extend our appreciation to the GAO staff for this thorough and objective study, and we would also like to thank you Mr. Chairman for occasioning this timely and appropriate examination of the federal oversight of the Joint Commission's accreditation process. I would be pleased to respond to any questions you may have.

STATEMENT

OF THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS

concerning

THE ACCREDITATION PROCESS OF THE JOINT COMMISSION

before

THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

June 21, 1990

EXECUTIVE SESSION

Mr. Chairman and members of the Committee, I am Dennis S. O'Leary, M.D., President of the Joint Commission on Accreditation of Healthcare Organizations. By letters of June 12 and June 17, 1990, you have asked that the Joint Commission discuss its accreditation process and provide specific information concerning all hospitals which, during the last twelve months, have been granted conditional accreditation, have lost their accreditation, or have been the subject of an adverse decision that is under appeal. Consistent with your request, we have provided to your staff copies of reports respecting these hospitals, with your assurances that this Subcommittee shall protect the confidentiality of the documents and the information contained therein.

The accreditation process, which has become increasingly sophisticated, today supports a thorough, balanced, and rigorous evaluation of hospital performance. However, during the development of this complex process, the Joint Commission has experienced unexpected and difficult problems, which are discussed below.

The Accreditation Manual for Hospitals contains approximately 2000 standards which are applied by the survey team during the hospital evaluation. Standards that are the subject of particular emphasis in the survey are identified by asterisks in the manual.

Before they may conduct hospital surveys, surveyors receive two weeks of intensive training. This is followed by participation in eight surveys during which they are preceptored. Approximately 10% of surveyor candidates fail to complete the training period.

Surveyors are trained in the use of a 1-5 scoring scale in assessing compliance with each standard. Detailed scoring guidelines have been prepared to assist surveyors in scoring compliance and to promote consistency in surveyor performance.

Surveyors are fundamentally information-gatherers and are not directly involved in the accreditation decision. Their findings and supporting documentation are provided to the Joint Commission on surveyor report forms which are immediately front-loaded onto our computer.

The computer is programmed to consistently weight and aggregate the multiple findings and provides a ready format for our analyst staff to assure that there is appropriate documentation to support non-compliance scores (3, 4 or 5). When the analysis is complete, the computer produces an accreditation decision grid which aggregates the survey findings into approximately fifty performance areas (each rated on a 1-5 scale). The summary grid score is a major consideration in the final review process that leads to the accreditation decision.

The computer program also establishes what follow-up activities (on-site visits or written progress reports or both) will be required and within what timeframes these are to occur. The timeframes for these follow-up activities begin to run on the date that the survey report is mailed.

All Type I recommendations (formerly contingencies) require follow-up which in a majority of instances involves an on-site visit. Over 90% of hospitals receive one or more Type I recommendations. Each follow-up activity generates a report which includes a determination as to whether the deficiency

(deficiencies) has been resolved. Hospitals that fail to resolve a deficiency after two attempts are subject to loss of accreditation. The Joint Commission produces approximately 13,000 reports with determinations each year.

During the past year, 75% of accredited hospitals have been the subject of full surveys or follow-up activities. Thirty-one percent of hospitals have been the subject of more than one activity, and 58% have received on-site follow-up visits.

With the exception of some remaining delays in the processing of conditional accreditation decisions, the accreditation process is currently running smoothly and on time. However, we must be honest in stating that this positive track record is of recent vintage.

Over the past five years, there has been a major transition in the accreditation process. During this time, the 1-5 scoring scale and the scoring guidelines were developed and implemented; the aggregation and decision rules that are applied to survey findings were created and introduced; and the entire survey analysis process was computerized. Each of these complex changes involved steep learning curves and integration with other changes in the process. The process of conversion from manual to computer analysis of survey findings, by itself, can only be characterized as an internal nightmare.

Computerization of the survey analysis process began in late 1985. The difficult conversion proved to be overwhelming, bringing the system to a virtual halt for almost a year. The resulting massive backlog of survey reports slowed the resolution effort, and introduction of additional "enhancements" to the accreditation process further compounded the problem. During 1987 and 1988, many routine reports were not provided to hospitals until almost a year following survey. For the more complex reports associated with problematic hospitals, the delays were often more extended.

Delayed processing of survey reports has consequences that reverberate throughout the system. As noted, follow-up activities are not initiated until the report is issued. With follow-up timeframes ranging from one to 18 months for on-site visits and written progress reports, completion of follow-up activities often could not be completed before the next full survey. In these instances, deficiencies were usually administratively cleared pending the results of the next regular survey. In retrospect, it is apparent that a small but significant number of hospitals had failed to resolve pre-existing deficiencies.

In 1989, steady progress was made towards clearing the survey report backlog and a major consultant study later that year accelerated the resolution process. Today, the backlog has virtually been eliminated, and the Joint Commission is well within its established 90-day turnaround requirement for survey reports. The parallel implementation of quality controls and monitoring mechanisms makes it unlikely that our earlier problems will recur.

We believe the foregoing information--both the positive attributes of the accreditation process and the difficulties the Joint Commission has experienced in transitioning to a more sophisticated system--is germane to today's discussion. We have shared this information with the GAO as part of its on-going study of the Joint Commission and feel that it should be shared with the Subcommittee as well.

In 1989, the Joint Commission created a new "conditional accreditation" category as a possible survey outcome. Conditional accreditation procedures became effective for accreditation surveys conducted on or after July 1, 1989. Coincidentally, the Joint Commission altered its confidentiality policy to provide that the survey findings that underlie a conditional accreditation or non-accreditation decision would be provided to the Administrator of the Health Care Financing Administration (HCFA).

These initiatives were undertaken at the sole determination of the Joint Commission to support the following objectives:

- To promote more effective collaboration between the public and private sectors in evaluating hospital performance.
- To assist HCFA in fulfilling its obligation to monitor the quality of care in Medicare hospitals.
- To permit both the Joint Commission and HCFA to focus their remedial efforts on identified marginal hospitals.
- To prompt these marginal hospitals to expedite efforts to improve performance.

The conditional accreditation procedures, which are also generally applicable to hospitals that may be subject to non-accreditation decisions, represent a marked improvement over previous Joint Commission approaches to addressing problematic hospitals. As such, these processing procedures differ from those applied to other hospitals.

Potentially problematic hospitals are flagged to the Joint Commission staff either by the surveyors or upon an initial reading after the survey findings are entered into the computer. These survey findings are then diverted to a special unit for intense review. If a preliminary adverse decision is reached, the findings are provided to the hospital which may then challenge the validity of the findings <u>at the time of the survey</u>. No credit is given for potential improvements since the time of survey. Hospitals which challenge the findings may submit additional documentation or opt for a further survey to re-examine the findings. It is our experience thus far that this exercise often results in changes in our recommendations but rarely affects the basic accreditation decision.

Following further analysis, the accreditation decision is reached and is shared with HCFA and all state licensure agencies. Concurrently, the decision becomes public information, and in fact, the health trade press have widely publicized the identity of conditionally accredited and non-accredited hospitals since these procedures were implemented.

Once the conditionally accredited hospital has received its survey report, it has 30 days to submit a Plan of Correction which is subject to Joint Commission approval. When the Plan of Correction has been approved, both it and the survey findings are transmitted to HCFA. A follow-up survey of the hospital is then conducted six months following approval of the Plan of Correction. The findings resulting from this survey lead to a decision to accredit or non-accredit the hospital. These survey findings are also provided to HCFA.

Under ideal circumstances, the time between the survey and the adverse accreditation decision may be as short as 90-120 days. In practice, however, we have experienced significant delays in a number of instances. These delays are primarily a consequence of lack of staff experience in using the new procedures but are also related to the time necessary to address hospital challenges. As experience has grown and as systems efficiencies have been realized, the timelines are being reduced. At the present time, we have 25 potential adverse decisions in house that are in various stages of the process; this has been reduced from 59 several months ago.

The conditional accreditation procedures are obviously designed both to assure the appropriate identification of problematic hospitals and to afford these hospitals due process. Even given optimal efficiency, each step takes time, and the aggregate amount of time required may, on the surface, seem worrisome, since patients are continuing to receive care in these institutions. At the same time, failed compliance with our standards (or with the conditions of participation) does not definitively establish a hospital as an actual danger to patient care. Our assessments, like those of HCFA, are best characterized as determinations of the degree of general risk to patients over an extended period of time.

On occasion, our surveyors do identify truly dangerous situations that constitute serious and immediate threats to patients. When advised of such situations, I as President am authorized to immediately remove a hospital's accreditation and notify appropriate government officials. I have had occasion to exercise this authority on several occasions.

When the new procedures were implemented, we estimated that approximately 8% of hospitals would be the subject of adverse decisions. Although our experience is limited, this estimate thus far appears to be accurate. For the relevant one-year time period, the non-accreditation rate is 1.3% and the conditional accreditation rate is 6.9%.

Hospitals receiving an adverse decision most commonly have multiple standards compliance problems. However, our analysis of the findings in these hospitals indicates a preponderance of difficulties in standards compliance for medical staff functions, as compared to other hospitals. Thus, quality assurance, drug usage review, surgical case review, blood usage review, and medical record review are common areas of non-compliance. Clinical privileging is also an apparent problem area. By contrast, nursing, safety management, and life safety standards compliance levels are generally comparable to those in other hospitals.

We believe that the new conditional accreditation procedures are moving on the right track and will permit realization of the objectives that were initially set forth. We are keenly aware of the sensitivity of the issues surrounding problematic hospitals and are committing our full efforts to achieve the processing timelines that were originally established for the new procedures.

I am pleased to have the opportunity to share this information with the Subcommittee and would be willing to respond to any questions you may have.

Dr. O'LEARY. There has been an issue that has been eating me a little bit as we have been through the executive and open session today. That is, how much of a distinction is there truly between joint commission standards and the Medicare conditions of participation?

I think that in their original conception, there was a substantial gap between our standards and the minimum standards, but it is our observation, we have looked both at Federal standards and at State requirements over the past few years, that as public expectations have risen, so have those conditions, regulations, and what have you, so that today, in many respects, the gap between what we require and what Government requires is not great.

Now, we are often involved in cutting edge activities. I think our drug utilization or drug usage review standards were cutting edge of kinds of standards. But in other respects, we are quite parallel.

The problems with our standards today and with the conditions today, I would submit, are not that they are not, in quotes, at the right level. It is that they contain a number of extraneous requirements that are probably no longer and maybe never were relevant to quality of care.

I really speak to a number of structural requirements. This is an issue of substance, because it costs hospitals money.

Chairman STARK. You don't mean a structural building. You mean a system structure.

Dr. O'LEARY. Internal structure. You have to have a something committee. Who says you do in order to get the job done?

Yet, hospitals spend money to meet these requirements. If they are not necessary, we are wasting money.

Chairman STARK. You are leading into a question that Mr. Gradison raised this morning. It is not meant in a pejorative or any other sense.

But the one thing we haven't touched upon until you raised it now, is do we know that jumping through all these hoops, in fact, produces less deaths or fewer infections?

I don't know. Maybe we will not know that until we have a lot of outcomes researched and have more data. I am not sure that that is something.

Maybe you know that. You are raising that now. Have we got a lot of vestigial processes we are going through because somebody dreamed them up a couple of years ago and everybody thought they ought to have one?

Dr. O'LEARY. I think the answer to the last is yes. We can go through our standards and the conditions and find those things where people speaking honestly would say this doesn't have anything to do with quality of care.

The more compelling issue is the things we still do believe in our heart of hearts make a difference. That is, that it makes a difference that you should monitor blood usage and infection and so on and so forth and the further belief that we ought to invest resources into assuring that these things are done. The question is still unanswered as to whether that has a payoff.

Now, I will wager on the side that it will have a payoff. But the data are not there yet. And we will spend much of the 1990s learning of those correlations, and parenthetically, how that data and those correlations can help us improve care and, indeed, the standards, as well.

Chairman STARK. I think you and I, at least, and the GAO, are saying the same thing. I am not sure that HCFA is.

There is some bedrock level. We haven't quite clearly established that, at least in the government below which the hospital cannot go.

Now, if they go there, we close them. If there is that level, it is different. It is different for the States, it is different for you, it is different for HCFA.

That does not help much. That does not help the public understand. If that is the way we are going to enforce this by informing the public, what are we telling them?

I do not think there is, certainly in the minds of the average American, a standard that they understand. I don't believe if it is open, it must be good. I think that that is the way they would judge it.

That doesn't even begin to touch the totality of what you want hospitals to do. I am just saying at the beginning that would be an

average rate of three for most of your hospitals, or three and a few fours. You want to see them all get ones and twos; right?

Dr. O'LEARY. Yes.

Chairman STARK. Keep going.

Dr. O'LEARY. I think you raise a critical question. I think if we all put our heads together, we would end up probably agreeing pretty much that the hospital that loses its accreditation probably also ought to lose its Medicare funding and probably ought to be closed by the State licensure agency.

Chairman STARK. It would be easier for all of us if all those things were the same. They wouldn't shop for a forum.

Dr. O'LEARY. I would guess de facto they are not that different, but none of us have sat down to work that out together.

I think, in a sense, that characterizes a lot of the evaluation activities that touch the hospital field. They are not sufficiently coordinated. We would raise the issue of PRO's and how they play into an evaluation process. They are looking at hospital care, too.

Yet the involved agencies do not speak to each other, coordinate with each other. That is a problem in the system. This is another symptom of that problem.

Chairman STARK. What should we do?

Dr. O'LEARY. Well——

Chairman STARK. What would you advise me? You understand, I think, the dilemma that is facing us. There is some question as to whether we should make more of this information public.

That is what I would suggest, that we should get HCFA to revise standards. We should speed up the process somehow. The information should be translated into coordinated action by States, then HCFA and yourself.

How do you put all this together? Where should we start?

Dr. O'LEARY. To me, the key element is, as of the past 2 days, is OBRA 1989. The Secretary, HHS, can ask for information now and we can give him information under statutory protection.

HCFA needs to know the right questions to ask. We can help, I think, with that. I am sure they will have plenty of good questions on their own.

It is not as gross a process as "send me all your survey reports". There is no point in having trucks running back and forth between Chicago and Washington, but refining the questions to identify major problem areas which on our grids are fives—a five is a problem. There is a high degree of likelihood that when you have a five on one of our grids, that there is a Medicare condition of participation that is out, that that hospital is not in compliance with that.

That kind of very specific information transmittal or the sharing of accreditation grids, those one-page things we showed you this morning, that is much simpler, conveys a lot of information, and answers the kinds of questions HCFA ought to be asking.

That informs the patients, for instance, of saying well, Hayward Hospital, just to pick an example, had a five in this area and when did the joint commission follow up on that, and what was the result of the followup.

I think we agree very much with HCFA, one of the key elements that has been missing from the validation process is any HCFA

awareness of what our total activities—followup activities are and what the results are.

You know, just standing aside from all of this, I don't see how you could have a good validation process absent that kind of information. But we are very willing to provide that information.

Beyond that, which really tracks itself down to communication and sharing of the right information, and I think I can assure that will happen, the broader issue of sharing information with the public is an issue that officially the joint commission takes a neutral position on.

Our position is that that is a matter of public policy. The Congress decides it. If the information is public, that is the way it will be.

At a permanent level, I would urge, as I think you have stated, that information provided to the public be provided to them in a useful fashion, in a context that they will be able to understand, so that it is meaningful to them as consumers.

I think that that is doable, also.

Chairman STARK. Let me try this. You are a doctor. I can get into a hospital on your say-so or the emergency room; right?

Dr. O'LEARY. Yes.

Chairman STARK. People don't go to hospitals just for a fun weekend.

Dr. O'LEARY. Relatively few.

Chairman STARK. What duty do you have to me?

Let's say we get to a red light, yellow light, green light situation. I can understand that. Red and yellow, I go right through if I am in Washington. Green, I look for the other guy coming through it.

So maybe the hospital has a yellow light, as a doctor, you don't have to tell me. You are going to operate on me. It has a yellow light. Do you have a duty maybe to tell me that this isn't the best of hospitals?

Say, this is the only hospital, I have to drive 100 miles to get to it. There is some question about whether it meets the standards. I am going to check it, but you, as my doctor ought to be aware of this.

If it has a red light, do you, as a doctor, have an absolute duty to warn me? Should the doctors participate with us in this sense?

They really are the people who interpret hospitals for us. If we find some standards, should we bring physicians into the loop?

Dr. O'LEARY. I think the answer to the question simply is yes. I will tell you that there are not a small number of practicing physicians out there who view our requirements as burdensome and bureaucratic because we require all of this review and documentation and everyone knows how wonderfully everything is going and who needs to do all of this.

Chairman STARK. I hate to tell you what they think about me.

Dr. O'LEARY. We can probably share war stories sometime.

In its actual, applied real-world situation, the doctor may say the hospital is in a little trouble with the joint commission, but I am not so sure whether that should worry you, the patient. I don't know what weight the average practicing physician would place upon that information.

Chairman STARK. I am not aware, but I would love to have that in a malpractice case.

I can understand if it is the doctor's hospital and so having to say that means that he or she can't practice. Then you have a real conflict.

Maybe you have different levels of worry in rural areas than you do, say, in urban areas where there is a choice. I don't know whether most doctors practice at more than one hospital or not.

But when we say in the case of medical care that the public ought to decide, I am always very skeptical because the public never really does. They take their doctor's word and do what the doc says, and hope a lot.

Therefore, I do wonder if there ought to be some requirement that physicians inform people too. Then we would know.

We always say the public ought to know, we ought to put out press releases, we ought to disseminate this information.

But it may soon be forgotten. I don't know who would read this. I don't read the restaurant cockroach ratings in the Washington Post. I really do not care about them.

But if I went to my doctor, he ought to have the current information on the various hospitals that are available. I would think it would be incumbent upon him if it had a red light, if it was the kind of hospital that you would say "buyer beware", that I would think personally that the doctor ought not to send me there unless the alternative was that I had no where else to go.

Would you agree there is some level at which that ought to be part of the doctor's responsibility?

Dr. O'LEARY. Yes. I think that, in the broad scope, certainly speaking from my perspective, that that is the kind of information that should be made available to the patient and where the decisionmaking is really being made by the physician, the physician ought to be sharing that information and is more likely to be aware of that information than John Q. Public.

Chairman STARK. I am not intruding on his independence, am I, when I talk about that kind of thing? I am very nervous about saying we are getting into the issue of telling a doctor how to practice medicine.

Dr. O'LEARY. I guess I would turn it around into a professional liability context and say it would be in the best interests of the physician to make that information known because although things will probably go well, if they don't go well and something happens to the patient and the physician knew that information and didn't share it with the patient beforehand, the physician probably has some exposure.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. You want to be sure the medical director in the hospital has informed the physicians with privileges that that had happened, because if your report only goes to those three people, they may not necessarily distribute the information to all physicians who practice there. I mean, a lot of those who have privileges may not practice there very often and may not regularly be there.

You want to be sure that all doctors have the information. My other question is, What is the relationship between this and State licensure? After all, if the hospital loses its accreditation but re-

tains its licensed physician, what does that say? How different is your process from State licensure and how much of a quality assurance is State licensure?

Dr. O'LEARY. My personal opinion as a generic comment is that it is not very much. That is with all due respect to many of my good colleagues in the State licensure agencies.

Mrs. JOHNSON. Does it vary a lot from State to State?

Dr. O'LEARY.. It varies a lot. New York is tough. A lot of States are pretty underfunded and pay little attention of any substance. There is a fairly populous State in the eastern half of this country in which we are negotiating with the State licensure agency.

We have actually sat down with the Secretary of Health and asked the question of whether they were going to rely on our findings. The concern was really not that we would miss something.

Rather, the concern was what were they going to do when we told them about these conditionally accredited hospitals. The Secretary sat there and talked to the director of the agency and asked when was the last time we even put a hospital on probation, and no one could remember.

Yet if you assume that conditional accreditation is somewhat akin to the threat of licensure loss in that State, you would probably have at least 25 hospitals on probation over a 3-year period. So, there are some differences. They are real enough. This is not a schlock State. It is a pretty good one.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Chairman STARK. Dennis, thank you very, very much.

I hope you will continue to counsel with us. I am so concerned about yelling "wolf" too often. As I think back, we talked about hospitals in my district, so I can call the newspapers and say, hey, there are the bad guys, but the people will forget it.

Dennis, would you share my opinion and Dr. Wilensky's opinion, that we ought to make this information more generally available to the public than it is now?

Dr. O'LEARY. I think that there is a place for useful information.

Chairman STARK. What is the argument about confidentiality? What will the hospital say?

Dr. O'LEARY. Well, I think—there are a couple of things you hear. Neither of them are invalid.

One is the information in its present form—for instance, in our accreditation reports—may mislead or confuse the public or not be understandable to them, and since our reports are not written for public consumption, I would have to say, yes, I agree with that.

The other concern is that there are some inherent variabilities in the survey process. A surveyor is not a surveyor is not a surveyor. We do have human variation.

There are variations amongst my surveyors. We try to reduce that. It is not zero.

There will be variations from our surveys to HCFA surveys. There will always be variances and there will be concerns raised that information was shared that was actually just a result because they had a quirky surveyor.

Those can be partially dealt with. They are partially valid.

I think the biggest problem that we are dealing with is a historical problem. That is in this field, information has not been widely

shared. I draw a distinction with the long-term care field and home care, where information is pretty widely shared with the public.

We have a long history of being a little close to the vest and moving people to be more open is part of this process.

One of the great concerns that we heard was that if you shared more information with hospitals, hospitals would not be willing to share information with our survey teams when we came on site. A good survey really requires collegial working relationships.

In the States where our surveys are public, and there are 13 of those States, we have seen no chill on the survey process. I am sure that it is an issue that we can get around, but I think the key issue is having the public and hospitals both feel confident that we are correct and fair and the other obstacles then will evaporate.

Chairman STARK. Again, thanks very much for your patience. You have been with us a long time today. We very much appreciate it. We will look forward to your helping us wind our way through this thicket.

Thanks very much.

Dr. O'LEARY. Thank you.

Chairman STARK. The hearing is adjourned.

[Whereupon, at 2 p.m., the hearing was adjourned.]

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